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# IN THE SUPREME COURT OF THE UNITED STATES OCTOBER TERM, 1994

FLORENCE NIGHTINGALE NURSING SERVICE, INC.,
*Petitioner,*

v.

BLUE CROSS AND BLUE SHIELD OF ALABAMA,
*Respondent.*

**Petition for a Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit**

## PETITION FOR A WRIT OF CERTIORARI

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## QUESTION PRESENTED

Whether absent special circumstances, a district court should ordinarily award attorney's fees under 29 U.S.C. § 1132(g)(1) to a plaintiff who prevails in a civil action seeking health or pension benefits under an ERISA employee benefit plan, an issue on which the federal courts of appeal have divided.

TABLE OF CONTENTS

QUESTION PRESENTED ..... i

TABLE OF AUTHORITIES ..... iii

OPINION BELOW ..... 2

JURISDICTION ..... 2

STATUTORY PROVISIONS INVOLVED ..... 2

STATEMENT OF CASE ..... 2

REASONS FOR GRANTING THE PETITION ..... 6

I. THE CIRCUIT COURTS HAVE ADOPTED CONFLICTING STANDARDS FOR DETERMINING WHETHER TO AWARD ATTORNEY'S FEES TO ERISA PLAN PARTICIPANTS WHO PREVAIL IN A CIVIL ACTION SEEKING PLAN BENEFITS. ..... 6

II. THE CHOICE OF STANDARD FOR AWARDING FEES IN ERISA BENEFITS CASES BEARS AN IMPORTANT RELATIONSHIP TO THE SECURITY OF WORKING AMERICANS IN THEIR EMPLOYEE HEALTH AND RETIREMENT BENEFITS. ..... 10

CONCLUSION ..... 16

APPENDIX ..... A1

# TABLE OF AUTHORITIES

*Cases:* Page

*Armistead v. Vernitron Corp.*, 944 F.2d 1287 (6th Cir. 1991).....7, 10

*Bowen v. Massachusetts*, 487 U.S. 879 (1988).....11

*Davidson v. Canteen Corp.*, 957 F.2d 1404 (7th Cir. 1992).....10

*Dixon v. Seafarers' Welfare Plan Welfare Plan*, 878 F.2d 1411 (11th Cir. 1989).....5, 10

*Eaves v. Penn*, 587 F.2d 453 (10th Cir. 1978).....6, 7, 12

*Eddy v. Colonial Life Insurance Co. of America*, 844 F.Supp. 790 (D.D.C. 1994).....8, 11

*Ellison v. Shenango, Inc.*, 956 F.2d 1268 (3d Cir. 1992).....10

*Freeman v. Continental Insurance Co.*, 996 F.2d 1116 (11th Cir. 1993).....4, 5, 10

*Gray v. New England Telephone Co.*, 792 F.2d 251 (1st Cir. 1986).....7

*Hechenberger v. Western Electric Co., Inc.*, 786 F.2d 347 (8th Cir.), *cert denied*, 479 U.S. 849 (1986).....9

*Hensley v. Eckerhart*, 461 U.S. 424 (1983).....9

*Hooper v. Demco, Inc.*, 37 F.3d 287 (7th Cir. 1994)...8, 14

*Iron Workers Local No. 272 v. Bowen*, 624 F.2d 1255 (5th Cir. 1980).....6, 10

TABLE OF AUTHORITIES--Continued

*Cases--Continued:*

*Landro v. Glendenning Motorways, Inc.*, 625 F.2d 1344 (8th Cir. 1980).....5, 8, 9

*Losado v. Golden Gate Disposal Co.*, 950 F.2d 1395 (9th Cir. 1991).....8

*Lutheran Medical Center v. Contractors Health Plan*, 25 F.3d 616 (8th Cir. 1994).....8, 10

*McElroy v. United States*, 455 U.S. 642 (1982) .....6

*McPherson v. Employees' Pension Plan of American Re-Insurance Co., Inc.*, 33 F.3d 253 (3rd Cir. 1994) .....7, 8

*Mendez v. Teachers Insurance and Annuity Association and College Retirement Equities Fund*, 982 F.2d 783 (2nd 1992) .....7

*Meredith v. Navistar Int'l Transp. Corp.*, 935 F.2d 124 (7th Cir. 1991).....8

*Nachwalter v. Christie*, 805 F.2d 956 (11th Cir. 1986).....6

*Nelson v. EE&G Energy Measurement Group*, 37 F.3d 1384 (9th Cir. 1994).....8

*Newman v. Piggie Park Enterprises, Inc.*, 390 U.S. 400 (1968).....9

*Pitts By and Through Pitts v. American Security Life Insurance Co.*, 931 F.2d 351 (5th Cir. 1991).....7

TABLE OF AUTHORITIES--Continued

*Cases--Continued:*

*Quesinberry v. Life Insurance Co. of North America*, 987 F.2d 1017 (4th Cir. 1993).....7, 10

*Ramsey v. Colonial Life Insurance Company of America*, 12 F.3d 472 (5th Cir. 1994).....10

*Smith v. CMTA-IAM Pension Trust*, 746 F.2d 587 (9th Cir. 1984).....5, 8, 9

*Stanton v. Larry Fowler Trucking, Inc.*, 1995 U.S. App. Lexis 7493 (8th Cir. 1994).....8

*Statutes:*

ERISA § 2(b), 29 U.S.C. § 1001(b).....9, 12

ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B).....3

ERISA § 502(e)(2), 29 U.S.C. § 1132(e)(2).....11

ERISA § 502(g)(1), 29 U.S.C. § 1132(g)(1) .....*passim*

42 U.S.C. § 1988.....9

42 U.S.C. § 2000a-3(b).....9

*Miscellaneous:*

Ann C. Bertino, *The Need For A Mandatory Award of Attorney's Fees For Prevailing Plaintiffs In ERISA Benefits Cases*, 41 Catholic L. Rev. 871, 885 (1991).....13

*ERISA Attorneys' Fees: An Unpredictable Situation*, 1 ERISA Litigation Rep. No. 9, at 14 (1992).....14

TABLE OF AUTHORITIES--Continued

*Miscellaneous--Continued:*

Thomas D. Rowe, Jr., *The Legal Theory of Attorney Fee Shifting: A Critical Overview* 1982 Duke L. J. 651.....13

IN THE

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OCTOBER TERM, 1994

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No. ___

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FLORENCE NIGHTINGALE NURSING SERVICE, INC.,
*Petitioner,*

v.

BLUE CROSS AND BLUE SHIELD OF ALABAMA,
*Respondent.*

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## PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

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Florence Nightingale Nursing Service, Inc., respectfully prays that a writ of certiorari issue to review the judgment and opinion of the United States Court of Appeals for the Eleventh Circuit in this case.

## OPINION BELOW

The opinion of the Court of Appeals for the Eleventh Circuit is reported at 41 F.3d 1476, and is reprinted in Appendix A. The unreported memorandum opinion of the United States District Court for the Middle District of Alabama denying attorney's fees is reprinted in Appendix B. The memorandum opinion of the district court on the underlying dispute is reported at 832 F.Supp. 1456, and is reprinted in Appendix C.

## JURISDICTION

The opinion of the court of appeals was entered on January 9, 1995. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

## STATUTORY PROVISIONS INVOLVED

Section 502(g)(1) of ERISA, 29 U.S.C. § 1132(g)(1) provides as follows: "In any action under this title by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs to either party."

## STATEMENT OF CASE

Frank Lungarella became sick with AIDS while he was an employee of Intergraph Corporation, an Alabama corporation. Intergraph sponsored an ERISA covered medical benefits plan for its employees. Blue Cross/Blue Shield of Alabama ("BC/BS"), the Respondent in this case, was the claims administrator for the Plan.

By its terms, the Plan provided reimbursement for medically necessary home nursing care. During the last two

months of his illness, Mr. Lungarella required such care around the clock. Petitioner here, Florence Nightingale Nursing Service, Inc., [1] which specializes in providing skilled nursing care for AIDS patients, provided the necessary care. Mr. Lungarella assigned his claims to reimbursement from the Plan to Nightingale.

Nightingale billed the Plan at $47.50 per hour for the first 12 days of nursing care, when an IV device was maintained, and $42.50 per hour for care during the final 47 days of Mr. Lungarella's life, after the IV was discontinued. BC/BS refused to pay all of Nightingale's charges for the 12-day period when the IV was maintained, finding such charges "unreasonable," and refused to pay any part of Nightingale's charges for the final 47 days of Mr. Lungarella's life, finding the nursing services during this period medically unnecessary because of the discontinuance of the IV device.

As assignee of Mr. Lungarella's claims, Nightingale sued BC/BS in a state court of its home state, California. The action was removed to a Federal district court in California and ultimately transferred to the district court for the Northern District of Alabama. App. A, A4. On BC/BS's motion, the district court in Alabama dismissed the action without prejudice to permit Nightingale to exhaust Plan administrative remedies. After exhausting such remedies, Nightingale renewed its civil action in federal court.[2] App. A, A5.

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1 Florence Nightingale Nursing Service, Inc., is a corporation with no subsidiaries, parent, or other affiliations.

2 The district court had jurisdiction under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B).

In 1993, more than six years after Nightingale had provided care for Mr. Lungarella, the district court ruled in its favor, awarding Nightingale the difference between what it had billed for its services to Mr. Lungarella and what BC/BS had paid, plus prejudgment interest.

Nightingale then petitioned for attorney's fees under section 502(g)(1) of ERISA, 29 U.S.C. § 1032(g)(1), which provides that "the court in its discretion may allow a reasonable attorney's fee and costs of action to either party." The attorney's fees, which the district court found no reason to question, App. B, B1, exceeded the entire recovery to Nightingale.[3] The court denied the petition for fees.

In denying fees, the district court noted that the Eleventh Circuit in *Freeman v. Continental Insurance Co.*, 996 F.2d 1116, 1119 (11th Cir. 1993), had identified "five factors for a trial court to consider in deciding whether or not to award attorney's fees and expenses to a prevailing party in an ERISA case."[4] The district court stated that it had

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[3] The court did recognize a probable distinction between hours spent before or during internal plan review procedures and hours spent thereafter. App. B, B1.

[4] The five factors identified in *Freeman* are

(1) the degree of the opposing parties' culpability or bad faith; (2) the ability of the opposing parties to satisfy an award of attorney's fees; (3)whether an award of attorney's fees against the opposing parties would deter other persons acting under similar circumstances; (4) whether the parties requesting attorney's fees sought to benefit all participants and beneficiaries of ERISA plan or to resolve a significant legal question regarding ERISA itself; (5) the relative merits of the parties' position.

*See Freeman v. Continental Insurance Co.*, 996 F.2d 1116, 1119 (11th Cir. 1993). The *Freeman* five factors are a variation of a five-factor standard developed by the Tenth Circuit in *Eaves v. Penn*, 587 F.2d 453

"considered all of the factors which it feels are apropos to this case." App.B, B3. The district court's opinion, however, only identified and discussed one of the five *Freeman* factors, the degree of BC/BS's bad faith.[5] App. B, B3.

Nightingale appealed the denial of fees, arguing that the Eleventh Circuit should adopt a presumption that a prevailing plaintiff in a benefits dispute is entitled to a reasonable fee, absent unusual circumstances that would render such an award unjust. The Eighth and Ninth Circuits have expressly adopted such a presumption. *See, e.g., Smith v. CMTA-IAM Pension Trust*, 746 F.2d 587, 589 (9th Cir. 1984); *Landro v. Glendenning Motorways, Inc.*, 625 F.2d 1344, 1356 (8th Cir. 1980).

The Eleventh Circuit panel declined Nightingale's invitation to adopt a prevailing-plaintiff presumption, noting that it had "previously expressly rejected this contention" in *Dixon v. Seafarers' Welfare Plan*, 878 F.2d 1411, 1412 (11th Cir. 1989). Concluding that the district court had not abused its discretion under the five-factor standard, the panel affirmed the district court's denial of Nightingale's attorney's fees.[6]

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(10th Cir. 1978) and adopted in one form or another by a majority of Federal courts.

[5] The district court was unwilling to "say that Blue Cross acted in bad faith" because the Plan's benefit decisions had been "neither entirely irrational nor corrupt." App. B, B2.

[6] BC/BS separately appealed the district court's holdings regarding the Plan's liability for Nightingale's fees for services provided to Mr. Lungarella and the district court's award of prejudgment interest. The Eleventh Circuit consolidated the two appeals. In its opinion, the Eleventh Circuit affirmed that the district court had "correctly determined" that BC/BS's refusal to pay Nightingale's fees was "incorrect" under the Plan. The Eleventh Circuit also affirmed the district court's award of prejudgment interest.

## REASONS FOR GRANTING THE PETITION

### I. THE CIRCUIT COURTS HAVE ADOPTED CONFLICTING STANDARDS FOR DETERMINING WHETHER TO AWARD ATTORNEY'S FEES TO ERISA PLAN PARTICIPANTS WHO PREVAIL IN A CIVIL ACTION SEEKING PLAN BENEFITS.

One of the primary bases for certiorari jurisdiction is the existence of "a conflict among the circuits on th[e] issue of statutory construction." *McElroy v. United States*, 455 U.S. 642, 643 (1982). This case presents a direct conflict among the circuits involving the proper interpretation of ERISA § 502(g)(1), 29 U.S.C. § 1132(g)(1). That provision provides that a district court may in its discretion award attorney's fees to either party in an ERISA dispute. The conflict arises because eight circuits apply one standard and two another standard in determining whether a plan participant who prevails in a benefits denial dispute should receive an award of reasonable attorney's fees.[7]

A majority of federal circuits apply a five-factor balancing test originally developed by the Tenth Circuit in the 1978

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[7] This petition does not present other questions arising under ERISA § 502(g)(1), such as the appropriate standard for determining whether to award fees to a prevailing defendant, *see e.g.*, *Nachwalter v. Christie*, 805 F.2d 956, 962 (11th Cir. 1986), or to a plan trustee in a suit between trustees, *see Iron Workers Local No. 272 v. Bowen*, 624 F.2d 1255 (5th Cir. 1980).

case of *Eaves v. Penn*, 587 F.2d 453 (10th Cir. 1978).[8] The five factors are

> (1) the degree of the offending parties' culpability or bad faith; (2) the degree of the ability of the opposing parties to satisfy an award of attorney's fees; (3) whether or not an award of attorney's fees against the offending parties would deter other persons acting under similar circumstances; (4) the amount of benefit conferred on members of the pension plan as a whole; and (5) the relative merits of the parties' positions.

*Eaves*, 587 F.2d at 465. Other circuits that have adopted the *Eaves* test or some close variation of it are the First Circuit, *see Gray v. New England Telephone Co.*, 792 F.2d 251, 258-59 (1st Cir. 1986); the Second Circuit, *see Mendez v. Teachers Insurance and Annuity Association and College Retirement Equities Fund*, 982 F.2d 783 (2nd Cir. 1992); the Third Circuit, *see McPherson v. Employees' Pension Plan of American Re-Insurance Co., Inc.*, 33 F.3d 253 (3rd Cir. 1994); the Fourth Circuit, *see Quesinberry v. Life Insurance Co. of North America*, 987 F.2d 1017, 1029-30 (4th Cir. 1993); the Fifth Circuit, *Pitts By and Through Pitts v. American Security Life Insurance Co.*, 931 F.2d 351, 358 (5th Cir. 1991); and the Sixth Circuit, *Armistead v. Vernitron Corp.*, 944 F.2d 1287 (6th Cir. 1991).[9] *See also,*

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[8] The *Eaves* test was developed in a case in which the issue was whether attorney's fees should be paid out of plan assets or by fiduciaries who breached their responsibilities to the plan. *See* note 13, *infra*, for further discussion of the *Eaves* test.

[9] Some circuits have somewhat modified the *Eaves* factors. For example, in *Eaves*, the fourth factor considers the benefits conferred on the plan as a whole, while in the Eleventh Circuit's *Freeman* opinion, the fourth factor also considers whether the case resolved a significant legal question under ERISA. *See supra* note 4. There have also been differences in judicial perception of how the factors should be

*Eddy v. Colonial Life Insurance Co. of America*, 844 F.Supp. 790 (D.D.C. 1994). The Seventh Circuit has used both a five-factor test and a test focusing on whether the defendant's position was substantially justified. *See Hooper v. Demco, Inc.*, 37 F.3d 287, 294 (7th Cir. 1994).[10]

In contrast to both the predominant five-factor balancing standard and the Seventh Circuit's "substantially-justified" formulation, the Ninth and Eighth Circuit Courts of Appeals each hold that under their five-factor test, a plan beneficiary who succeeds in an action to enforce rights under an ERISA-covered employee benefit plan should recover attorney's fees "unless special circumstances would make such an award inequitable." *E.g., Stanton v. Larry Fowler Trucking, Inc.*, 1995 U.S. App. Lexis 7493 (8th Cir. 1995) (specifically reaffirming commitment to prevailing-plaintiff presumption); *Nelson v. EE&G Energy Measurement Group,* 37 F.3d 1384 (9th Cir. 1994); *Lutheran Medical Center v. Contractors Health Plan*, 25 F.3d 616, 623-24 (8th Cir. 1994) (civil action by assignee of beneficiary entitled to plan benefits); *Losado v. Golden Gate Disposal Co.*, 950 F.2d 1395 (9th Cir. 1991); *Smith v. CMTA-IAM Pension Trust*, 746 F.2d 587, 589 (9th Cir. 1984); *Landro v. Glendenning Motorways, Inc.*, 625 F.2d 1344, 1356 (8th Cir. 1980). Thus, courts in these

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interpreted. *Compare McPherson v. Employees' Pension Plan*, 33 F.3d 253 (3rd Cir. 1994) (first factor weighs in favor of fees if defendant is culpable *or* acts in bad faith) with *Florence Nightingale Nursing Service, Inc. v. Blue Cross/Blue Shield of Alabama*, App. A, A18 n.5. (rejecting distinction).

[10] In *Hooper*, the Seventh Circuit stated that the "bottom line question" in both tests is, "was the losing party's position substantially justified and taken in good faith, or was that party simply out to harass its opponent?" *Hooper*, 37 F.2d at 294 (quoting *Meredith v. Navistar Int'l Transp. Corp.*, 935 F.2d 124, 128 (7th Cir. 1991)). The Seventh Circuit test thus described appears to focus primarily on whether the losing party acted in good or bad faith.

circuits ordinarily award attorney's fees to prevailing plaintiffs who sued for benefits, unless special circumstances are present, such as bad faith on the part of the plaintiff. *See Hechenberger v. Western Electric Co., Inc.*, 786 F.2d 347 (8th Cir.), *cert. denied*, 479 U.S. 849 (1986) (special circumstances present when plaintiffs filed an appeal that "continued to challenge a practice that not only had been abandoned before trial but had never been applied to them").

The Eighth and Ninth Circuits base their endorsement of the prevailing-plaintiff standard on its consistency with ERISA's explicitly stated policy goals of protecting employee rights and securing effective access to federal courts, 29 U.S.C. § 1001(b). *See, e.g., Smith v. CMTA-IAM Pension Trust*, 746 F.2d 587 (9th Cir. 1984); *Landro v. Glendenning Motorways, Inc.*, 625 F.2d 1344, 1356 (8th Cir. 1980) (ERISA fee provisions should be construed in favor of the participants ERISA was intended to protect). Both circuits have analogized ERISA's discretionary fee language to similar language in the civil rights statutes, which although granting courts discretionary authority to award fees has been interpreted as mandating payment of fees to prevailing plaintiffs in the absence of special circumstances.[11] *See Newman v. Piggie Park Enterprises, Inc.*, 390 U.S. 400 (1968) (courts should exercise their discretion to award attorney's fees under Title II of Civil Rights Act to prevailing plaintiffs "unless special circumstances would render such an award unjust"); *Hensley v. Eckerhart*, 461 U.S. 424 (1983)(same standard under Civil Rights Attorney's Fees Awards Act of 1976).

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[11] There is a difference between the regular ERISA fee provision and the fee provisions of the civil rights statutes. ERISA provides that a court may in its discretion award fees to either party. The civil rights statutes provide that a court may in its discretion award fees to a prevailing party only. See 42 U.S.C. § 1988 (Civil Rights Attorney's Fees Awards Act of 1976); 42 U.S.C. § 2000a-3(b).

Six circuit courts of appeals have nevertheless expressly considered and rejected the "prevailing-participant" standard. *See Quesinberry v. Life Insurance Co. of North America*, 987 F.2d 1017, 1029-30 (4th Cir. 1993); *Davidson v. Canteen Corp.*, 957 F.2d 1404, 1409 (7th Cir. 1992); *Ellison v. Shenango, Inc.*, 956 F.2d 1268 (3d Cir. 1992); *Armistead v. Vernitron Corp.*, 944 F.2d 1287 (6th Cir. 1991); *Dixon v. Seafarers' Welfare Plan Welfare Plan*, 878 F.2d 1411, 1412 (11th Cir. 1989); *Iron Workers Local No. 272 v. Bowen*, 624 F.2d 1255 (5th Cir. 1980).

There are, then, at least two distinct standards for awarding attorney's fees to prevailing plaintiffs in suits for benefits under a plan.[12] Such sharply differing standards will necessarily yield sharply diverging outcomes. In this case, for example, Nightingale was denied fees even though the district court held that BC/BS's denial of reimbursement was arbitrary and capricious. Had Nightingale brought its suit in the Eighth Circuit, the district court would have awarded fees unless BC/BS could demonstrate "special circumstances" that would make such an award inequitable. *See Lutheran Medical Center v. Contractors Health Plan*, 25 F.3d 616, 623-24 (8th Cir. 1994). For other examples of courts denying fees to prevailing plaintiffs in benefits cases where the five-factor test governs, *see, e.g., Ramsey v. Colonial Life Insurance Company of America*, 12 F.3d 472 (5th Cir. 1994) (plaintiff recovered medical benefits but fees denied primarily "because there was no showing of a bad faith denial of benefits" by defendant); *Quesinberry v. Life Insurance Co. of North America*, 987 F.2d 1017, 1029-30 (4th Cir. 1993) (death benefits); *Freeman v. Continental*

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12 The Seventh Circuit approach, with its particular emphasis on the losing party's good or bad faith, may reflect a third standard. *See* note 10, *supra*.

*Insurance Co.*, 996 F.2d 1116, 1119 (11th Cir. 1993) (disability benefits); *Eddy v. Colonial Life Insurance Co. of America*, 844 F.Supp. 790 (D.D.C. 1994).

The different standards encourage forum-shopping by plaintiffs--an especially vexing problem given ERISA's unusually broad venue provisions, *see* ERISA § 502(e)(2), 29 U.S.C. § 1132(e)(2)--and will also encourage motions by defendants to transfer cases to more hospitable venues. "Nothing is more wasteful than litigation about where to litigate." *Bowen v. Massachusetts*, 487 U.S. 879, 930 (1988) (dissenting opinion).

Equally troubling, many ERISA employee benefit plans operate on a multistate level, covering employees who may reside and work in numerous Federal judicial circuits, thereby creating the possibility of inconsistent judicial treatment of participants in the same plan. Moreover, plan participants who live in judicial circuits where fees are not routinely awarded may find it more difficult to locate attorneys willing to represent them than participants in circuits in which fees are ordinarily awarded. Similarly, in deciding whether to settle benefit claims before they boil over into litigation, some plan administrators will surely consider whether the circuit in which the dispute arose is one that ordinarily awards attorney's fees. Such inconsistencies are embarrassing to the notion of fair and equal treatment for all citizens; the conflict between the circuits warrants correction by the Court.

## II. THE CHOICE OF STANDARD FOR AWARDING FEES IN ERISA BENEFITS CASES BEARS AN IMPORTANT RELATIONSHIP TO THE SECURITY OF WORKING AMERICANS IN THEIR EMPLOYEE HEALTH AND RETIREMENT BENEFITS.

Section 2(b) of ERISA, 29 U.S.C. § 1001(b) proclaims that "[i]t is hereby declared to be the policy of this Act to protect . . . the interests of participants in employee benefit plans and their beneficiaries, . . . by providing [inter alia] ready access to the Federal courts." As the Eighth and Ninth Circuits have noted, a standard that ordinarily awards attorney's fees to plaintiffs who prevail in benefit disputes unless special circumstances would make an award unjust is consistent with this expression of policy. By awarding fees to prevailing plaintiffs in the absence of special circumstances that would render such an award unjust, the Eighth and Ninth Circuits ensure that participants and their beneficiaries receive the full value of old-age and health benefits that ERISA was enacted to protect, unreduced by the cost of retaining an attorney.

Indeed, this case provides a vivid illustration of how attorney's fees can entirely consume a benefit if the fees are not included in the plaintiff's recovery. The attorney's fees billed to Nightingale in this litigation exceed the amount, including prejudgment interest, that the district court awarded Nightingale for its provision of nursing services to Mr. Lungarella.

The prevailing-plaintiff standard also is consistent with providing participants the ready access to Federal courts that Congress identified as a central policy of the Act. By ensuring the payment of attorney's fees in benefits cases unless special circumstances are present, the prevailing-

plaintiff standard also ensures that participants and their beneficiaries will be able to locate attorneys willing to take their cases. Without such assurance, many attorneys will be unable to afford to undertake representation of participants seeking benefits from ERISA plans unless the benefits sought are sufficiently substantial to make a contingency-fee arrangement viable. But the benefits of many participants in ERISA health and retirement plans are simply too small to make such contingency arrangements feasible. *See* Ann C. Bertino, *The Need For A Mandatory Award of Attorney's Fees For Prevailing Plaintiffs In ERISA Benefits Cases*, 41 Catholic L. Rev. 871, 885 (1991) (noting modest level of average pension benefits).

Three different theories of fee-shifting support the Eighth and Ninth Circuits' prevailing-participant standard: (1) providing full compensation to a wronged party; (2) equalizing an imbalance of litigation resources between plaintiff and defendant; and (3) providing economic incentives for plaintiffs to bring meritorious cases. *See generally*, Thomas D. Rowe, Jr., *The Legal Theory of Attorney Fee Shifting: A Critical Overview*, 1982 Duke L. J. 651, 653-666 (1982).

In contrast, the *Eaves* five-factor standard, which provides district courts nearly unbridled discretion to award or deny fees, is consistent with no coherent theory of fee shifting other than letting the judge decide on an ad-hoc basis which theory of fee shifting should be applied in a particular case.[13]

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[13] Ironically, the decision in *Eaves* v. *Penn*, 587 F.2d 453 (10th Cir. 1978), that initially identified the five factors that now govern fee awards in most circuits, was a case in which plan fiduciaries were forced to restore to the plan losses resulting from their breach of duties. The district court awarded attorney's fees from the recovery to the plan because the planitffs had created a benefit for other plan participants. The Secretary of Labor argued that the fees should come from the pocket

The absence of a consistent theoretical underpinning to the predominant five-factor balancing standard creates a host of problems for ERISA and the plan participants it protects. Judicial determinations under the standard are necessarily inconsistent from court to court. The standard invites wasteful factitious litigation. Each time a court denies attorney's fees under the standard, it diminishes the benefits promised to the participant and discourages attorneys from accepting ERISA cases in the future. And it serves as a disincentive for plan administrators to settle cases, even cases that they know they will probably lose if the participant is able to retain an attorney.

When courts focus on whether a defendant acted in bad faith, as the district court did in this case and as the Seventh Circuit apparently now does routinely, *see Hooper v. Demco,*

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of the wrongdoing fiduciaries rather than out of the plan's coffers. The Tenth Circuit reversed and remanded the case, noting that ERISA section 502(g), 29 U.S.C. § 1132(g), reflected a Congressional intent "that the offending party bear the costs of the award, rather than non-culpable, non-party plan participants." *Eaves*, 587 F.2d at 464. In remanding the case, the appellate court instructed the trial court to consider the now well-known five factors.

The authors of the ERISA Litigation Reporter comment on the rapid spread of the five-factor standard to other circuits:

> Its spread has been surprising in two respects. First, although conceived in *Eaves* as a test for determining whether fees should be paid either from a common fund or from an offending party, it quickly metamorphosed into a test for determining whether one party's fees should be paid by another. Second, given that the factors emerged in *Eaves* without citation and apparently from thin air, their widespread acceptance in other circuits is remarkable. Undoubtedly, the generality and elasticity of the five factors explains why they have appealed to so many courts.

*ERISA Attorneys' Fees: An Unpredictable Situation*, 1 ERISA Litigation Rep. No. 9, at 14 (1992).

*Inc.*, 37 F.3d 287, 294 (7th Cir. 1994), the problems are exacerbated. If such becomes the effective standard under the rubric of the five factors, judges seldom will award fees to participants who prevail in actions for benefits wrongfully denied them. This will embolden some plan administrators to deny meritorious benefit claims so long as the administrator has some justification just this side of frivolous for the denial. Under such circumstances, if the plan participant cannot find a lawyer, the plan pays nothing. If the plan participant can find a lawyer and prevails in the litigation, the plan pays only the benefits that it should have paid in the first place. It is a win/no-lose situation, except for the working Americans who depend upon ERISA plans to help them through periods of illness and to sustain them in their old age.

The choice of standard for awarding fees in ERISA benefits cases has important consequence to the security of Americans in their health and retirement benefits and warrants consideration by the Court.

## CONCLUSION

The Court should grant the petition for writ of certiorari.

Respectfully submitted,

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# APPENDIX

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## APPENDIX A

**United States Court of Appeals,**
**Eleventh Circuit**

**FLORENCE NIGHTINGALE NURSING SERVICE, INC., California corporation,**

**No. 93-6867**

***Plaintiff-Appellee,***

**v.**

**BLUE CROSS/BLUE SHIELD OF ALABAMA,**

***Defendant-Appellant***

**v.**

**FLORENCE NIGHTINGALE NURSING SERVICE, INC., California corporation,**

**No. 93-6918**

***Plaintiff-Appellant,***

**v.**

**BLUE CROSS/BLUE SHIELD OF ALABAMA,**

***Defendant-Appellee.***

**Jan. 9, 1995.**

**DUBINA, Circuit Judge:**

In Case No. 93-6867, Blue Cross/Blue Shield of Alabama ("Blue Cross") appeals the district court's judgment entered in favor of Florence Nightingale Nursing Service, Inc. ("Nightingale") in this ERISA/insurance benefits action. 832 F.Supp. 1456. Based upon our review of the record, we affirm. In a companion case, Case No. 93-6918, Nightingale appeals the district court's order denying its motion for

attorney's fees in its suit against Blue Cross. Because we hold that the district court did not abuse its discretion in denying Nightingale's motion for attorney's fees, we also affirm the district court's judgement in that case.[1]

## BACKGROUND

Nightingale provided skilled home nursing care between July 8, 1987, and September 5, 1987, in Fort Lauderdale, Florida, to Frank Lungarella ("Lungarella"), who was in the later stages of the AIDS virus. Prior to the onset of his illness, Lungarella was an employee of Intergraph Corporation ("Intergraph") and, as such, was covered by Intergraph's Medical Benefits Plan for Active and Retired Employees ("the Plan"). The Plan is governed by ERISA (Employee Retirement Income Security Act), 29 U.S.C. § 1001, *et seq.* Blue Cross was and is the claims administrator for the Plan and, in that capacity, had the fiduciary responsibility for receiving, processing, and paying claims. The Plan is self-funded by Intergraph.[2]

The Plan document provided that private duty skilled nursing care was a covered benefit to the extent such care was "medically necessary." The Plan did not cover "custodial care" because the Plan did not deem skilled nursing in a private home environment "medically necessary." Nightingale billed Blue Cross for services rendered to Lungarella at an hourly rate of $47.50 for the 268 hours of service between July 8, 1987, and July 19, 1987, a period during which Lungarella

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[1] By separate order, we consolidated these two cases for purposes of this appeal.

[2] Under Blue Cross's agreement with Intergraph, Blue Cross is paid a percentage of claims paid. Blue Cross receives no payment for claims that it denies. Although the Intergraph Plan is completely self-funded, it was drafted using a Blue Cross form according to the Blue Cross model.

underwent intravenous ("IV") treatment at home under nursing supervision. Nightingale charged a reduced rate of $42.50 per hour for the 1,132 hours between July 20, 1987, when the IV was removed, and September 5, 1987, the date or Lungarella's death. The Plan provided that only "reasonable" charges would be paid.

After a non-jury trial, the district court found that prior to providing home care to Lungarella, Ms. Warren, Nightingale's owner, telephoned Blue Cross. A Blue Cross representative orally assured her that Lungarella's home care was covered. Warren mailed a letter confirming her telephone conversation with the Blue Cross representative. Nightingale produced a copy of this letter at trial; Blue Cross said that it could not find its copy. The letter stated that Nightingale's understanding was that it would be reimbursed 100% for the private duty nursing, and that if this understanding was inaccurate, Blue Cross should notify Nightingale within five days. Warren never received a response from Blue Cross to her letter.

Until this dispute arose, Blue Cross never told Nightingale what it would consider to be a "reasonable" charge if Nightingale's regular and customary charge was not deemed "reasonable," nor did it indicate what home nursing care was or was not "medically necessary." The Plan defines "charge" as follows:

> Charge means the reasonable charge by a provider of covered services or supplies not exceeding the provider's actual charge regularly and customarily made for these services or supplies.

The Plan defines "medically necessary" as follows:

> Medically Necessary means the use of a Hospital or the furnishing of other services or supplies which are necessary to treat a Member's illness or injury. To be Medically Necessary, the services and supplies furnished must (as

determined by the claims administrator):

> be appropriate and necessary for the symptoms, diagnosis, or treatment of the Member's condition, disease, ailment, or injury; and be provided for the diagnosis or direct care of Member's medical condition; and be in accordance with standards of good medical practice accepted by the organized medical community; and not be solely for the convenience of the Member, his family, his Physician or another provider of services; and not be Experimental or Investigative; and be performed in the least costly setting the Member's medical condition requires.
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> A "setting" may be a Member's home . . . .

After Nightingale billed Blue Cross at $47.50 and $42.50 per hour, Blue Cross responded by reimbursing Nightingale at the rate of $19.00 per hour for the services rendered prior to July 19, 1987 (IV care), and by paying nothing for the services rendered after July 19, 1987 (after the IV was discontinued). Blue Cross posits that a charge of $47.50, which is obviously substantially in excess of Blue Cross's pre-determined $19.00 per hour for skilled private duty nursing, is not "reasonable." Blue Cross also contends that after the IV was discontinued, Lungarella was only under "custodial care" not requiring skilled nursing, during which time Nightingale's services were no longer "medically necessary." Essentially, Blue Cross maintains that Lungarella's family was capable of providing all of the care he needed after the IV's were removed.

After Blue Cross refused to pay Nightingale's invoice in full, Nightingale filed suit in the Superior Court of the State of California. Blue Cross removed the case to the United States District Court for the Central Division of California. That court subsequently transferred the case to the Northern District of Alabama.

One of Blue Cross's first defenses was that Nightingale had failed to exhaust internal administrative remedies available under the Plan. Accordingly, the district court dismissed the action without prejudice in order that Nightingale might seek an internal administrative remedy.

The parties then presented their contentions to Dr. Renee Holloway ("Holloway"), who was and is Blue Cross's Assistant Medical Director and chief claims evaluator. The irony here is that Blue Cross's own legal department was opposing Nightingale in front of Holloway, Blue Cross's claims evaluator.[3] Holloway did not conduct an oral hearing, choosing instead to rely on written documentation. She also considered Blue Cross's internal guidelines and material regarding nursing rates obtained *ex parte* by Blue Cross investigators. Before Holloway released her findings, Blue Cross's in-house counsel edited her opinion. This in-house counsel later served as Blue Cross's corporate representative at trial. Except for ordering additional reimbursement for a few hours of what she found to be "medically necessary" private duty nursing following the extraction of the IV, Holloway agreed completely with Blue Cross's initial evaluation of the case.

After Holloway made her findings, Nightingale again filed suit in the district court. The district court conducted a bench trail and entered findings in favor of Nightingale. The district court ordered full reimbursement for Nightingale's services, along with substantial prejudgment interest. Blue Cross then perfected its appeal (Case No. 93-6867).

After the district court entered its judgment, Nightingale filed a petition for attorney's fees and expenses pursuant to ERISA's § 502(g)(1), 29 U.S.C. § 1132(g)(1). The petition was timely filed and

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[3] The district court referred to this relationship as "an incestuous situation." RII-75-9.

included all necessary supporting documentation. The district court denied the request for a fee award. Nightingale then perfected its appeal (Case No. 93-6918).

## ISSUES

In Case No. 93-6867, Blue Cross presents the following issues for review:

(1) Whether the district court improperly applied heightened scrutiny under the arbitrary and capricious standard in reviewing Blue Cross's administrative decision.

(2) Whether the district court erred as a matter of law by not upholding Holloway's decision that $19 per hour was the reasonable charge for care rendered during July 8-July 20, 1987.

(3) Whether the district court erred in holding that the post-July 20 care was medically necessary.

(4) Whether the district court abused it discretion in applying Alabama's insurance interest statute in awarding prejudgment interest.

In Case No. 93-6918, Nightingale contends that the district court erred in denying its motion for attorney's fees without first affording Nightingale an opportunity to be heard and, in denying the motion for attorney's fees, the district court applied an erroneous legal standard.

## DISCUSSION

*Case No. 93-6867*

A. *Standard of Review Used by the District Court*

Blue Cross first takes issue with the district court's

decision not to apply the deferential arbitrary and capricious standard of review. In deciding this case, the threshold question for the district court was the proper standard of review to apply to Blue Cross's denial of Lungarella's claim. The Supreme Court has held that, as a general matter, courts should review claims administrators' denials of ERISA benefits under a *de novo* standard. *Firestone v. Bruch*, 489 U.S. 101, 109 S.Ct. 948, 103 L.Ed.2d 80 (1989). In *Firestone*, the Court held that the arbitrary and capricious standard of review is often too lenient in that it "would afford less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted." *Id.* at 113-14, 109 S.Ct. at 956 (citations omitted).

The *Firestone* decision provided for the use of the arbitrary and capricious standard only in the specific case where the plan document explicitly vests the claims administrator with discretion to "construe disputed or doubtful terms." *Id.* at 111, 109 S.Ct. at 954. However, deference in such situations is greatly diminished when the claims administrator is acting under a conflict of interest. *Id.* at 115, 109 S.Ct. at 957. This court has held that when a conflict of interest is apparent, "the burden shifts to the fiduciary to prove that its interpretation of plan provisions committed to its discretion was not tainted by self-interest." *Brown v. Blue Cross & Blue Shield of Alabama, Inc.*, 898 F.2d 1556, 1566 (11th Cir. 1990) (citations omitted), *cert. denied,* 498 U.S. 1040, 111 S.Ct. 712, 112 L.Ed.2d 701 (1991).

In addition, this court recently delineated the analysis to be used in deciding cases like the present. *See Lee v. Blue Cross/Blue Shield of Alabama*, 10 F.3d 1547, 1549-52 (11th Cir. 1994). First, a court must establish whether the claimant has proposed a "reasonable" interpretation of the plan under which he could be covered. *Id.* at 1550. If the plan grants the claims administrator discretion to interpret disputed provisions, however, the next step is to consider whether the claims

administrator's interpretation was arbitrary and capricious. *Id.* at 1550. If the claimant has established a reasonable interpretation, then under *contra proferentem*. which requires ambiguities to be construed against the drafter of a document, the claimant's interpretation is taken as correct. *Id.* at 1551.[4] Where no conflict of interest is present, a claims administrator's wrong but reasonable interpretation will not be found arbitrary and capricious. *Id.* at 1550. However, if a conflict of interest is established, the burden shifts to the administrator to prove that his or her interpretation of the plan was not tainted by self-interest. *Id.*

In the present case, the district court heard the testimony of Holloway and spent a significant amount of time considering the possibility of a conflict of interest. The district court chose to discount Holloway's evaluation and subsequent testimony due to a number of conflicts. The first conflict noted by the district court was Blue Cross's desire to maintain its business relationship with the employer-insurer. Holloway's testimony established that Intergraph is Blue Cross's customer; that Intergraph pays Blue Cross fees for services; and that Blue Cross likes to please its customers. RIII-74-39, 40. Holloway further testified that she understood that Intergraph could fire Blue Cross at any time for any reason. *Id.* at 44. The district court noted that each week Intergraph deposits $93,000 with Blue Cross and stated that this provided ample self-interest for Blue Cross to please Intergraph.

The second conflict found by the district court was Blue Cross's strong pecuniary interest in the narrow interpretation of the relevant provisions of the Plan. Holloway testified that it did not matter whether Blue Cross was the insurer or whether an employer is the

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[4] Blue Cross's argument that *contra proferentem* should not apply to self-funded ERISA plans is specious. We held in *Lee*, 10 F.3d at 1551, that *contra proferentem* does not apply to ERISA plans.

actual insurer because if two different plans have exactly the same provision, she would interpret it the same way in both plans. RIII-74-47. Thus, Blue Cross's obligation to interpret contracts consistently means that the precedential effect of this decision would affect innumerable contracts that Blue Cross insures containing identical language. Accordingly, the district court found that Blue Cross is not an unbiased decision-maker when it interprets these provisions.

The third conflict found by the district court was that when the claims administrator rendered her administrative decision in this case, the claims administrator was fully aware that her employer had already engaged in two years of litigation in which it was fighting to deny this claim. This is evidenced by some procedural irregularities in Holloway's processing of the claim. Holloway's task was explained to her by a Blue Cross attorney from its in-house legal department who was intimately involved in advocating Blue Cross' position throughout this litigation. RIII-74, 54-55. This lawyer also assisted Holloway in editing her administrative opinion. RIV-74-287, 288.

Suffice it to say that our review of the record persuades us that there is ample evidence to support the district court's findings of a conflict of interest. We declined to overturn these findings because they are not clearly erroneous. *See Pullman-Standard v. Swint*, 456 U.S. 273, 287, 102 S.Ct. 1781, 1789, 72 L.Ed.2d 66 (1982).

Moreover, we are unimpressed with Blue Cross's argument on appeal; the mere fact that Blue Cross is compensated only for claims that it pays, as opposed to claims that it denies, like the one at issue here, cannot be used as an all-powerful talisman to ward off any possible conflict of interest charge. Certainly, in a case like this, in which the supposedly objective claims administrator is taking *ex parte* advice from the lawyer who is representing Blue Cross in front of her, Blue

Cross's reliance on its fee arrangement with Intergraph as its sole response to the charge of conflict of interest is rightly discounted.

In sum, we hold that Blue Cross is not entitled to the deferential arbitrary and capricious standard of review. It is Blue Cross's burden to prove that its decision is not tainted by self-interest and Blue Cross has failed to meet its burden.

B. *Reasonable charge*

Blue Cross contests the district court's findings that Nightingale's rate of $47.50 per hour, during the time that Lungarella had an IV, was reasonable. Blue Cross maintains that its settled rate of $19.00 per hour for private duty nursing is, in fact, the reasonable rate and that the district curt erred as a matter of law in not upholding it. Blue Cross relies heavily upon survey data detailing the rates charged for private duty nursing in the summer of 1987 in Lungarella's geographic location. A Blue Cross representative conducted a survey in which seven nursing service agencies responded. All services stated that they treated AIDS patients in their homes without charging extra for the service. The survey rates ranged from $13.50 to $27.00 per hour. Thus, Blue Cross argues that its $19.00 figure falls squarely in the middle.

The district court elected to discount Blue Cross's survey and chose to rely on the affidavit of Warren, describing customary charges for treating AIDS patients and the 1992 rates of All Care, the only other agency in the area which treated AIDS patients *exclusively*. There is sufficient evidence in the record to support the district court's findings.

First, the survey conducted by Blue Cross was totally bereft of statistical significance, as Holloway admitted in her administrative decision. RII-55-10, RII-63-Tabs 6, 10. Second, the failure of the Blue Cross

study to focus on nursing agencies that actually provide *substantial* services to AIDS patients is fatal to its reliability. Third, Warren offered inherently credible testimony that it costs more to find nurses willing to work primarily with AIDS patients, and that other nursing agencies regularly referred AIDS cases to Nightingale. Warren Dep. at 227, 230. Fourth, Warren testified that her rates were the going rates in the Ft. Lauderdale area in 1987 for private duty nursing for AIDS patients. RII-63-Tab 13-para. 6 at 3. Warren provided Blue Cross with the names of two AIDS-specialized nursing agencies in the Ft. Lauderdale area which she said had similar rates--All Care and High Tech. RII-55-8. The Blue Cross representative did not contact either of these agencies when she did her survey. Finally, in 1992, when Holloway was conducting her administrative review, she attempted for the first time to contact these agencies. She could not reach High Tech, but was able to make a rate inquiry of All Care. RIII-74-96,97. All Care's 1987 rates were in the archives, but the service informed Holloway that its current rates for private duty nursing service were $50.00 per hour for nursing care with IV, and $42.00 per hour otherwise. *Id.* at 97. Since both of these nursing services specialized in the treatment of AIDS patients and billed at similar rates, the All Care rates provided credible evidence supporting the reasonableness of Nightingale's rates.

Additionally, Nightingale's interpretation of the provisions in the Plan governing the rate to be paid was reasonable and correct. As previously noted, "charge" is defined in the Plan as the reasonable charge by a provider of covered services or supplies not exceeding the provider's actual charge regularly and customarily made for these services and supplies. RII-63-Tab 1-Sec. I.5 at 1. Thus, the "charge by a provider" is limited to two concepts: it must be reasonable; and it may not exceed the fee that the provider "regularly and customarily" charges for the specific service. The record supports the district court's

finding that Nightingale's $47.50 and $42.50 rates were "regular and customary." The rates charged by Nightingale in this case are the same that it charges all of its patients--it is Nightingale's "regular and customary" charge.

The district court correctly determined that Blue Cross's alternate reading of the "charge" language is not reasonable. In denying Nightingale's rates and substituting its own rate, Blue Cross relied on a pre-determined rate for private duty nursing. RIII-74-93, 76, 77. The Plan, however, makes no reference to a pre-determined rate in the definition of "charge." The Plan requires analysis of the provider's rate. Holloway testified at trial that she understood that she was to determined if the $19.00 rate was reasonable. RIII-74-99,100. This is an incorrect analysis. Holloway determined whether Blue Cross's pre-determined fee of $19.00 was reasonable, not whether the provider's fee was reasonable. According, the district court's holding as to the reasonable rate was not in error.

C. *Medically Necessary*

The district court determined that the care Nightingale rendered to Lungarella from July 20 until September 5, 1987, was "medically necessary" under the Plan definition. Blue Cross contends that the district court erred in its determination. We disagree.

The record demonstrates that the Nightingale nurses provided a variety of services during the last seven weeks of Lungarella's life that were essential to prolonging his life and maintaining its best possible quality as he suffered through the final days of his illness. The nurses provided care relating to Lungarella's outbreaks of herpes lesions on his coccyx. This care was especially important with Lungarella because AIDS patients experience incontinence of urine and feces and if not cleaned and treated can increase the risk of infection. The proximity of the lesions to

the sources of incontinence dictated rapid response. RIII-74-123-125, 130-134, 139-140. The nurses also monitored numerous indicators of Lungarella's health and filled out complex charts daily. The nurses were also prepared for emergencies. Lungarella had many sores on his mouth and tongue which made it difficult to eat and breathe. The nurses were present to deal with crises as they might arise; i.e., to clear his breathing tubes if they became clogged. The nurses also provided trained support for the numerous psychological problems associated with AIDS. As such, the district court correctly determined that the care Lungarella received in the last seven weeks of his life was "medically necessary."

Since Nightingale offered a reasonable interpretation of the "medically necessary" provision under which the care would be covered, according to *Lee v. Blue Cross/Blue Shield of Alabama*, 10 F.3d 1547 (11th Cir. 1994), Blue Cross must offer a reasonable interpretation under which the care would not be covered and prove its denial of the claim was not tainted by self-interest. Blue Cross has done neither. Holloway analyzed "medically necessary" under separate guidelines contained in another Blue Cross document that is not even mentioned in the Plan. RII-55-15, 16. These separate guidelines are contained in the "Pre-certification of Private Duty Nursing Policy." RII-63-Tab 8. This Pre-certification Policy enunciates a different definition of "medically necessary" than the one contained in the Plan. Holloway imported an additional requirement from the Pre-certification definition of "medically necessary" and injected it into her analysis. A claims administrator's decision is arbitrary and capricious where new requirements for coverage are added to those enumerated in the plan. *See Helms v. Monsanto Company, Inc.*, 728 F.2d 1416 (11th Cir. 1984) (holding a claims administrator's denial of disability benefits was arbitrary and capricious where he read a requirement of "no conscious life" into a plan definition of "total disability"). Holloway admittedly never

actually analyzed the elements of "medically necessary" that are listed in the Plan. RIII-74-159, 160. Accordingly, Holloway's decision was arbitrary and capricious, and the district court correctly determined that Holloway's decision was incorrect.

D. *Prejudgment Interest*

After finding for Nightingale at trial, the district court awarded prejudgment interest in the amount of 1.5% per month. In computing the interest rate, the district court consulted Ala. Code § 27-1-17(b) (1986), which provides the rate of interest to be paid by an insurer to an insured if a claim has been denied for invalid reasons. Blue Cross contends that this reliance was in error and that if interest was to be assessed at all, the district court should have applied Alabama's statutory interest rate of 6% per year. Blue Cross presents three arguments in support of its contention that the district court abused its discretion in awarding 1.5% monthly (18% annually) in prejudgment interest: (1) the insurance interest statute is preempted as to self-funded plans; (2) Blue Cross is exempted from the insurance interest statute; and (3) an award of interest to the provider and not to be the insured violates the express terms of the statute. None of these arguments persuades us that the district court erred in awarding prejudgment interest.

The award of an amount of prejudgment interest in an ERISA case is a matter "committed to the sound discretion of the trial court." *Moon v. American Home Assurance Co.*, 888 F.2d 86, 89-90 (11th Cir. 1989). It was clearly within the district court's discretion to use § 27-1-17(b) as an analogy to fill a gap in ERISA law. The district court noted:

> Whether § 27-1-17(b) is applied as a matter of Alabama law enforceable against Alabama health insurers like Intergraph or as a matter of federal common law arrived at by analogy, this court

> concludes that 1.5% per month is the proper interest rate to be applied in this case.

We see no abuse of discretion in this finding. Furthermore, Blue Cross's argument is contradictory: why would Alabama's statutory interest rate of 6% not also be preempted? Additionally, this court applied the Alabama interest statute in question in another insurance/ERISA case, *Jordan v. National Accident Ins. Underwriters, Inc.*, 922 F.2d 732 (11th cir. 1991), *certified answer conformed to*, 948 F.2d 1218 (11th Cir. 1991), but the court did so by declining to address the ERISA preemption issue.

Blue Cross's second argument that it is exempted from the insurance interest statute because it is not an insurance company is specious. The district court correctly found that a Intergraph's administrator, Blue Cross stood in the shoes of Intergraph and thus could not cloak Intergraph with immunity from the interest requirements by claiming exemption.

Blue Cross's last argument that an award of interest violates the express terms of the statute because the statute notes interest is to be paid by the insurer to the insured is also meritless. Blue Cross argues that Nightingale is the provider of the services, not the insured, and thus cannot be awarded interest because the Alabama Legislature clearly intended such awards to insureds, not providers. We think the more likely scenario, however, is that the legislature intended the interest provision to deter insurance companies from denying reimbursement without cause.

In conclusion, we affirm the judgment of the district court in Case No. 93-6867.

*Case No. 93-6918*

Nightingale argues that the district court erred in denying its petition for attorney's fees. A denial of a

petition for attorney's fees is reviewed for an abuse of discretion. *Freeman v. Continental Inc. Co.*, 996 F.2d 1116, 1118 (11th Cir. 1993); *Dixon v. Seafarers' Welfare Plan*, 878 F.2d 1411, 1412 (11th Cir. 1989).

Nightingale first contends that the district court erred in denying its petition for attorney's fees without a hearing, or at least, without a response from Blue Cross. Our circuit has made clear that district courts are not required to hold a hearing on the fee issue. "It is perfectly proper to award attorney's fees based solely on the affidavits in the record." *Norman v. Housing Authority of City of Montgomery*, 836 F.2d 1292, 1303 (11th Cir. 1988). However, we have noted that evidentiary hearings are occasionally necessary

> where an evidentiary hearing was requested, where there were disputes of fact, and where the written record was not sufficiently clear to allow the trial court to resolve the disputes of fact . . .

*Id.* This court has also instructed that

> [a] district court should give the applicant an adequate opportunity to respond to the court's concerns regarding the fee application and to correct perceived inadequacies in that application before making its decision. This is particularly necessary in the situation when the fee application is unopposed.

N.A.A.C.P v. City of Evergreen, Alabama, 812 F.2d 1332, 1338 (11th Cir. 1987). An evidentiary hearing was not necessary in this case because the district court had intimate knowledge of the case and received very detailed affidavits from Nightingale.

Nightingale's second argument is that the district court misapplied the law when it denied the petition for attorney's fees. Our court has enumerated five factors

for the district courts to consider when deciding a motion for attorney's fees: (1) the degree of the opposing parties' culpability or bad faith; (2) the ability of the opposing parties to satisfy an award of attorney's fees; (3) whether an award of attorney's fees against the opposing parties would deter other persons acting under similar circumstances; (4) whether the parties requesting attorney's fees sought to benefit all participants and beneficiaries of an ERISA plan or to resolve a significant legal questions regarding ERISA itself; and (5) the relative merits of the parties' positions. *Freeman v. Continental Ins. Co.*, 996 F.2d 1116, 1119 (11th Cir. 1993). In *Freeman*, we did not dictate that district courts discuss each factor.

The district court considered all of the *Freeman* factors it felt were "apropos." RII-88-4. The district court only discussed the first factor--bad faith. The district court found that Blue Cross had not acted in bad faith because it clearly had an arguable basis for its decision. See *Armistead v. Vernitron Corp.*, 944 F.2d 1287, 1304 (6th cir. 1991) (even though district court only considered bad faith in denying an award of attorney's fees, court would not remand for consideration of other four factors); Andrews v. Employers' Retirement Plan, 938 F.2d 1245, 1248 (11th Cir. 1991) (holding that lack of bad faith was dispositive and reversed the fee award on that basis). Since the district court heard the evidence and is in the best position to judge the propriety of awarding fees, we cannot say that the district court abused its discretion in denying Nightingale's petition for attorney's fees.[5]

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[5] Nightingale cites the recent case of *McPherson v. Employees' Pension Plan of American re-Insurance Co.*, 33 F.3d 252 (3rd Cir. 1994), in support of its argument that fee awards can be justified when the defendant is culpable--even absent bad faith. However, we note that this case is not binding precedent on our circuit.

Nightingale requests that this court adopt a presumption that attorney's fees be awarded to the prevailing party in ERISA cases. We have previously expressly rejected this contention. "The law provides no presumption in favor of granting attorney's fees to a prevailing claimant in an ERISA action." *Freeman*, 996 F.2d at 1119; *Dixon v. Seafarers' Welfare Plan*, 878 F.2d at 1412.

We decline Nightingale's self-serving invitation to make a new law on this issue.[6]

## CONCLUSION

The district court correctly determined that a conflict of interest existed in this case and that Blue Cross's denial of reimbursement was arbitrary and capricious. Therefore, the district court properly awarded judgement for Nightingale in Case No. 93-6867. Because the district court did not abuse its discretion in denying Nightingale's petition for attorney's fees, we affirm the district court's order in Case No. 93-6918.

**AFFIRMED.**

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[6] Additionally, we note that only our court sitting *en banc* or the Supreme Court can overrule existing law in our circuit. *Willis, Inc. v. Director. O.W.C.P.*, 31 F.3d 1112 (11th Cir. 1994).

**APPENDIX B**

**IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ALABAMA
SOUTHERN DIVISION**

**FLORENCE NIGHTINGALE NURSING SERVICE, INC.**

***Plaintiff,***

**vs.** **CIVIL ACTION NO. 91-AR-2236-S**

**BLUE CROSS AND BLUE SHIELD OF ALABAMA**

***Defendant.***

MEMORANDUM OPINION

After this court entered a money judgment in favor of plaintiff, Florence Nightingale Nursing Services, Inc. (Nightingale), and against defendant, Blue Cross and Blue Shield of Alabama (Blue Cross), Nightingale timely filed and supported by affidavits a motion for attorney's fees and expenses pursuant to Local Rule 54.1 and 29 U.S.C. § 1132(g)(1), which is the provision of the Employee Retirement Income Security Act of 1974 that allows fees and expenses to a prevailing party in an ERISA action.

This court does not question that Nightingale's counsel reasonably spent the number of lawyers-hours they say they spent, or the reasonableness of the hourly rates claimed, although the court does recognize a probable distinction between lawyer-hours spent before or during the exhaustion of internal review procedures ostensibly required by this particular medical benefit plan (even though they proved futile), and the lawyer-hours spent thereafter. This distinction, if it exists, becomes academic in view of this court's conclusion that this case is not one for the awarding of any attorney's fees or expenses to plaintiff pursuant to 29

U.S.C. § 1332(g)(1). It is for this reason that the court now reacts to Nightingale's request without oral argument and without awaiting a response from Blue Cross.

The issue here presented is controlled by the very recent Eleventh Circuit decision in *Freeman v. Continental Insurance Company*, 996 F.2d 1116 (11th Cir. 1993), which recognizes the trial court's broad discretion to award or deny attorney's fees and expenses to a prevailing party in a suit for ERISA benefits. Obviously, the first prerequisite for awarding fees to a plan participant is that he prevail. Nightingale has satisfied this prerequisite. But there are other factors that must be considered.

When evaluating a winning claimant's entitlement to fees, an important *Freeman* criterion upon which a trial court exercises it discretion is the defendant's degree of culpability or bad faith in denying the claim. Although this court has criticized Blue Cross for its self-interested motivation in denying Nightingale's claim, this court cannot say that Blue Cross acted in "bad faith." It clearly had an arguable basis for its decision. While there may not be a valid analogy between the Alabama tort of "bad faith refusal to pay" and the unjustified refusal to pay a medical benefits claim, that is, for the purposes of evaluating a fee request under 29 U.S.C. § 1132(g)(1), there is a certain attraction to the analogy. As everyone knows, there is no "bad faith" in Alabama if the insurance carrier has a legitimately debatable reason for not paying. Wrong though it was, Blue Cross's decision to pay only $19.00 per hour was neither entirely irrational nor corrupt.

Because ERISA has been construed to insulate plan administrators from extra-contractual damages, some courts take delight in socking it to fiduciaries with attorney's fees when they commit gross violations of their fiduciary obligations. The concept of awarding attorney's fees against the non-prevailing party has a punitive as well as a compensatory rationale. This court would find it hard not to be motivated by a desire, by awarding fees, to add to any lesson here taught Blue Cross had the court not already

applied a one-half percent per month interest rate to the principal sum due, and expected Blue Cross, and not Intergraph, to pay it. The court picked this interest rate as the most nearly analogous Alabama interest rate because the rate was designed to implement a public policy placing a penalty on the insurance provider who wrongfully fails to provide. In response to a question certified to it by the Eleventh Circuit, the Supreme Court of Alabama put it this way in *Jordan v. Reliable Life Ins. Co.*, 589 So. 2d 699 (Ala. 1992):

> Given the choice between 1) requiring insurers to bear the risk of a later judicial determination of invalidity and impropriety and 2) requiring those insured to forgo the benefits of policy proceeds they are rightfully entitled to, the former is more consistent with the overall intent of the legislators in regulating the insurance industry.

589 S. 2d at 702.

In *Freeman* the Eleventh Circuit lists five factors for a trial court to consider in deciding whether or not to award attorney's fees and expenses to a prevailing party in an ERISA case, but at the same time it recognizes that "no one of these factors is decisive," citing *Plumbers & Steamfitters Local No. 150 Pension Fund v. Vertex Const. Co., Inc.*, 932 F.2d 1443, 1452 (11th Cir. 1991). This court has considered all of the *Freeman* factors which it feels are apropos to this case and concludes that Nightingale's request for attorney's fees and expenses should be denied.

This opinion is, of course, not intended to pre-judge the question of attorney's fees incurred by Nightingale in defending the appeal taken by Blue Cross to the Eleventh Circuit and now pending.

DONE this 18th day of October, 1993.

William M. Acker, Jr.

United States District Judge

## APPENDIX C

**IN THE UNITED STATES DISTRICT COURT**
**NORTHERN DISTRICT OF ALABAMA**
**SOUTHERN DIVISION**

**FLORENCE NIGHTINGALE NURSING SERVICE, INC.,**

***Plaintiff,***

**v.** **Civ. A. No. 91-AR-2236-S**

**BLUE CROSS AND BLUE SHIELD OF ALABAMA,**

***Defendant.***

_____/

MEMORANDUM OPINION

August 26, 1993

**ACKER, District Judge.**

A hyperbolic wag is reputed to have said that E.R.I.S.A. stands for "Everything Ridiculous Imagined Since Adam." This court does not take so dim a view of the Employee Retirement Income Security Act of 1974. Instead, this court is willing to believe that ERISA has lurking somewhere within it a redeeming feature. However, this is not the case in which to find it. Instead, this case turns on mundane, routinely accepted principles offering little grist for the ERISA windmill.

Because ERISA does not permit trial by jury, the case was bench-tried, after which the parties filed comprehensive post-trial briefs. The record is too voluminous to be fully outlined in an opinion. The dispositive facts, as this court finds them, some of which are obviously more important than others, are as follows.

*Findings of Fact*

Plaintiff, Florence Nightingale Nursing Service, Inc. (Nightingale), a California entity, provided skilled home nursing care between July 8, 1987 and September 5, 1987, in Ft. Lauderdale, Florida, to Frank Lungarella (Lungarella) who was dying of Acquired Immune Deficiency Syndrome ("AIDS"). Prior to the onset of this horrible and terminal illness, Lungarella had been an employee of Intergraph Corporation (Intergraph) and, as such, was covered by Intergraph's Medical Benefits Plan for Active and Retired Employees (the Plan).

The Plan is governed by ERISA, 29 U.S.C. §§ 1001, *et seq*. Defendant, Blue Cross and Blue Shield of Alabama (Blue Cross), was and is the Claims Administrator for the Plan and in that capacity had the fiduciary responsibility for receiving, processing and paying claims. The Plan is self- funded by Intergraph. Nightingale's standing to sue as Lungarella's assignee of benefits under the Plan is not disputed.

At all times pertinent, the Plan document, which was contained within a folder labeled "Blue Cross" and not "Intergraph," provided that private duty skilled nursing care was a covered benefit to the extent such care was "medically necessary." The Plan did not cover "custodial care" because the Plan did not deem skilled attention in a private home environment "medically necessary." Nightingale billed Blue Cross for services rendered to Lungarella at an hourly rate of $47.50 for the 264 hours of service Nightingale delivered between July 8, 1987 and July 19, 1987, a period during which Lungarella underwent intravenous treatment at home under nursing supervision. Nightingale charged a reduced rate of $42.50 per hour for the 1,132 hours between July 20, 1987, when the intravenous needles ("I.V.'s") were removed, and September 5, 1987, the date of Lungarella's death. The Plan provided that only "reasonable" charges would be paid.

Prior to Nightingale's providing home care to Lungarella, Ms. Warren, Nightingale's owner, telephoned Blue Cross. An ostensibly authorized Blue Cross representative orally assured Ms. Warren that Lungarella's home nursing care was covered. Nightingale would not have provided the service had it not believed, rightly or wrongly, that Blue Cross would reimburse Nightingale at Nightingale's customary hourly rates for nursing AIDS patients, which was its exclusive business. Blue Cross says that it cannot find the letter that it received from Ms. Warren and which she mailed on or about July 9, 1987. The letter confirmed her said telephone conversation. Ms. Warren's letter stated:

FLORENCE NIGHTINGALE NURSING SERVICE
*Specializing in the Care of AIDS Patients*
P.O. Box 27
FT. LAUDERDALE, FL 33302
(305) 390-6544
(818) 362-6078
July 9, 1987

Jan Spradling

Blue Cross--Blue Shield of Alabama
P.O. Box 2504 Burmingham[sic] AL 35201

RE: F. Lungarella

Group #: INT 167-32-9299

Dear Ms. Spradling:

This letter is to confirm our telephone conversation of July 7, 1987. You stated that Mr. Lungarella's policy covers Private Duty Nursing. I was told that Mr. Lungarella has met his out of pocket expenses for the year, and that his Private Duty Nursing will be covered at one hundred percent.

A physician's Plan of Treatment, nurses' notes and all skilled documentation must be included in the billing.

Should there be a discrepancy in the policy, please notify me in writing within five days of receipt of this letter.

Sincerely,
/s/
Porter Warren, R.N.
Administrator

Blue Cross never answered Ms. Warren's letter and, until this dispute arose, never indicated what it considered to be a "reasonable" charge if Nightingale's regular and customary charge was not deemed "reasonable," and never signified what home nursing care was or was not "medically necessary."

The Plan defined "charge" as follows:

"Charge" means the reasonable charge by a provider of covered services or supplies not exceeding the provider's actual charge regularly and customarily made for these services or supplies.

The Plan defined "medically necessary" as follows:

"Medically Necessary" means the use of a Hospital or the furnishing of other services or supplies which are necessary to treat a Member's illness or injury. To be Medically Necessary, the services and supplies furnished must (as determined by the Claims Administrator):

be appropriate and necessary for the symptoms, diagnosis or treatment of the Member's condition, disease, ailment, or injury; and

be provided for the diagnosis or direct care of Member's medical condition; and

be in accordance with standards of good medical practice accepted by the organized medical community; and

not be solely for the convenience of the Member, his family, his Physician or another provider of services; and

not be Experimental or Investigative; and

be performed in the least costly setting the Member's medical condition requires.

A "setting" may be the Member's home, a Physician's office, a Participating Ambulatory Surgical Facility, a Hospital's outpatient department, a Hospital when the Member is an inpatient, or another type of facility providing a lesser level of care. Only the Member's medical condition is considered in deciding which setting is Medically Necessary. The financial or family situation of the Member, the distance he lives from the Hospital or other facility, or any other non-medical factor is not considered. As the medical condition of the Member changes, the setting he needs may also change. The Member should inquire of his Physician if any of his services can be performed on an outpatient basis, or in a less costly setting.

The Plan's definition of "usual, customary and reasonable fee," *a definition that, as will appear, clearly does not apply to home nursing services*, was as follows:

"Usual, Customary and Reasonable Fee" (often referred to as "UCR Fee") means the amount of a Physician's charge that the Claims Administrator will recognize for payment for his Medically Necessary services covered by this Plan. The amount recognized will not be more than the Physician's actual charge. In determining the "UCR Fee" of a Physician, the Claims Administrator considers:

(a) the "usual charge" which is most frequently charged by a particular Physician to his patients for the same or a similar service; and

(b) the "customary charge" which is the charge at the ninetieth percentile of the range of usual charges for the same or a similar service billed by most Physicians with similar training and experience within the geographic area (or in other areas, if it is determined by the Claims Administrator that these [sic] are too few charges for the same or similar service by other Physicians in the same area); or

(c) the "reasonable charge" which is whether the charge otherwise is reasonable in light of all the circumstances, including any unusual circumstances or complications requiring time, skill, or experience additional to that ordinarily required for the services; and

(d) either (a), (b) or (c) for the surgical procedure with the highest fee and one-half of (a), (b) or (c) for each of the other surgical procedures, when two or more surgical procedures are performed during the same operating session.

(emphasis supplied).

After Nightingale billed Blue Cross at $47.50 and $42.50 per hour, Blue Cross responded by reimbursing Nightingale at the rate of $19.00 per hour for the services rendered prior to July 19, 1987, and by paying nothing for the services rendered after July 19, 1987. Blue Cross then took, and still takes, the position that a charge of $47.50, which is obviously substantially in excess of Blue Cross's pre-determined $19.00 per hour for skilled private duty nursing (information that Blue Cross did not share with Nightingale), was not "reasonable." Blue Cross also contends that after the intravenous treatment was discontinued (with Lungarella's concurrence and with the concurrence of his family), he was only under "custodial

care" not requiring skilled nursing, during which time Nightingale's home services were no longer "medically necessary." In other words, Blue Cross asserts that Lungarella's family was entirely capable of providing the level of care which the dying man required at home after the "IV's" were removed. However, Lungarella could easily have been sent to a hospital instead of staying at home to die, and the hospital would, in all probability, have been paid under the Plan.

A sworn declaration executed on June 17, 1991, by Cynthia L. Moon, a knowledgeable Blue Cross employee, stated, *inter alia*:

> Blue Cross determined that the entire 279 hours of nursing services claimed were reimbursable at the rate of $19.00 per hour. *This rate was determined by Blue Cross to be the regular and customary rate for such services.*

(emphasis supplied). Ms. Moon did not proffer an opinion that Blue Cross's "regular and customary rate" was the only "reasonable charge" for the services rendered by Nightingale, or that Nightingale's rate was "unreasonable" considering all of the circumstances. Neither Ms. Moon nor any other Blue Cross employee has ever suggested that Nightingale's invoice to Blue Cross exceeded *Nightingale's* "regular and customary rate."

Blue Cross's rather enigmatic agreement with Intergraph for administering the Plan provided, *inter alia*:

> The purpose of this document is to identify the special agreements between Intergraph Corporation and Blue Cross and Blue Shield of Alabama for administration of the health and dental benefit plans of Intergraph Corporation.

* * * * * *

IV. *Financial*

1. Administrative Services Contract Only. No reinsurance thru Blue Cross and Blue Shield of Alabama.

2. Weekly deposit with Monthly Settlement. Intergraph will remit a weekly deposit beginning May 1, 1987. These deposits will be used to pay claims during the month. An invoice will be sent to Intergraph monthly for claims paid the previous month, plus the administrative fee. Deposits are credited against claims and a settlement made each month. The weekly deposits are waived from 3/1/87--5/1/87 because of initial claims startup. During these initial months, Intergraph will be invoiced for claims paid plus administrative fee.

* * * * * *

5. Notice of cancellation by either party will be done 30 days prior. In the event of cancellation, Blue Cross and Blue Shield of Alabama will process any and all claims incurred prior to cancellation date. All claims runout, including any applicable hospital retroactive adjustments, will be paid by Blue Cross and Blue Shield and invoiced to Intergraph until these claims are completed.

Weekly Deposit--$93,000.00 (includes health & dental)

Administrative Fee--5.2% of paid claims. Administrative fee is guaranteed to 1-1-89. An extension to 1-1-90 will be guaranteed pending no state or federal mandates have caused Blue Cross and Blue Shield administrative costs to increase. It is understood that if Pre-admission Certification is added at a future date during the period of 3-1-87 to 1-1-90, no increase in administrative fee will be charged because of Pre-admission Certification.

* * * * * *

7. Blue Cross and Blue Shield will perform the following services in exchange for the 5.2% administrative fee:

--Claim control activities, provider pricing information and third-party liability investigation.

* * * * * *

--Cost containment activities ... medical necessity activities.

This document was printed under the logo of Blue Cross and not under the logo of Intergraph. This court can find nothing in the written agreement between Blue Cross and Intergraph informing the two signatories as to which is responsible for the cost of defending a Plan beneficiary's litigated claim.

Although Blue Cross did not undertake to insure or to reinsure Intergraph's obligations under this plan, Blue Cross is itself a very large (if not the largest) Alabama group medical insurer. Blue Cross's own medical insurance plans contain provisions similar, if not identical, to those in this Plan. In fact, Blue Cross's internal guidelines are geared to the interpretation and application of terms and phrases which are not only central to this Plan but to plans designed and insured by Blue Cross. Blue Cross's business is medical insurance. Apparently, Intergraph's Plan was drafted using basically a Blue Cross form.

After Blue Cross refused to pay Nightingale's invoice in full, Nightingale filed this action on December 15, 1989, in the Superior Court of the State of California for the County of Los Angeles. The case was then removed by Blue Cross to the United States District Court for the Central Division of California, and thereafter transferred by that court to this court. One of Blue Cross's

first defenses was that Nightingale had failed to exhaust internal administrative remedies provided by the Plan. Therefore, on November 20, 1991, this court dismissed Nightingale's action in recognition of the prerequisite of exhaustion of the Plan's internal review procedures. This dismissal was without prejudice to reinstatement if the review procedure did not produce a result satisfactory to Nightingale. The parties thereafter spent a great deal of time and energy presenting to Renee Holloway, M.D., who was and is Blue Cross's Assistant Medical Director and chief claims evaluator, the very same issues Nightingale had attempted to present in its original complaint.

On December 2, 1992, present counsel for Blue Cross wrote a letter brief addressed to Dr. Holloway *"C/O Legal Department*, Blue Cross and Blue Shield of Alabama." (emphasis supplied). Intergraph was not resisting Nightingale's claim before the Claims Administrator. Rather, the Claims Administrator's own lawyers were opposing Nightingale before the Claims Administrator, which, in truth and fact, was Blue Cross's legal department. It was an incestuous situation. In "evaluating" the claim, Dr. Holloway did not conduct an oral hearing. Instead, she reviewed written materials submitted both by Nightingale and by Blue Cross. She also considered Blue Cross's internal guidelines and materials on rates obtained ex parte by Blue Cross investigators. Before releasing her findings and conclusions, her opinion was edited by Blue Cross's "in-house" counsel, who served as Blue Cross's corporate representative at trial. Except for ordering additional reimbursement for a few hours of what she found to be "medically necessary" private duty nursing after Lungarella stopped receiving intravenous treatment, Dr. Holloway agreed totally with her employer's legal position. Her findings closely tracked the brief submitted to her by Blue Cross's present counsel. This court still does not understand how she came up with the hours of "medically necessary" nursing after the "IV's" were removed.

At trial Dr. Holloway was the only live witness. She testified that she performed her "review" with instructions which differed from any under which she had ever performed. She had been instructed by Blue Cross's lawyers, who she described as being *her* lawyers, to determine a "reasonable" rate for the "medically necessary" services provided by Nightingale to Lungarella, not in her capacity as Assistant Medical Director of Blue Cross but as if she were an entirely independent judge (analogous to a special master?). In other words, she testified that she was not supposed to decide if Blue Cross's $19.00 per hour rate was "reasonable" or if Nightingale's $47.50 per hour rate was "reasonable" but instead that she was to independently arrive at the "reasonable" rate for these services. Only for the sake of argument, the court will make the assumption that Dr. Holloway started with no preconception or presumption in favor of her employer, Blue Cross. This assumption becomes impossible, however, because Dr. Holloway miraculously arrived precisely at Blue Cross's pre-determined $19.00 per hour as the "reasonable" rate, despite the undisputed fact that the said rate was the amount then regularly being paid by Blue Cross for *general* private duty nursing services. Blue Cross had no rate limited to private duty nursing specializing in home care to AIDS patients, a service that, without serious contradiction, is a high-risk enterprise with many unpleasant and unique treatment aspects not confronted in other skilled home care situations. No evidence was presented that anything about AIDS treatment is "average," particularly when mouth and body lesions must be treated while urine and feces are present during long periods of incontinence and despair. All Care, the only other nursing care supplier that exclusively serves AIDS patients and that was checked for its hourly home service rate, charged a rate of $50.00 per hour in 1992. Dr. Holloway totally rejected this figure as being irrelevant, on the ground that it was not a 1987 figure. Except for Nightingale's charge, which Nightingale obviously argues is reasonable, the All Care rate is the only charge for exclusive AIDS nursing services offered into evidence, probably because no other home nursing care services specialize in AIDS care.

Dr. Holloway chose not to believe that Ms. Warren mailed the letter of July 9, 1987, in effect deciding that the letter was an "after-the-fact" forensic invention by Nightingale. This court believes Ms. Warren over Dr. Holloway primarily because if Ms. Warren had wanted to make up something to help Nightingale's case she would have done a better job of it.

Dr. Holloway's training is not only in medicine but in "cost containment." In which of these disciplines she is better trained would be an interesting question with which to spend some time. Giving her the benefit of the doubt, she was assigned an impossible task. If Dr. Holloway had not previously proven her desire to please her employer, she certainly proved it, and her own lack of credibility, by concluding that after the "IV's" were removed the skilled nursing care provided by Nightingale was solely for the convenience of the member and/or of his family (Blue Cross's plan language). This court believes that Lungarella's lesions, infection, fever, incontinence, malnutrition, dehydration and the psychological impact of the situation on the patient and on his family made the presence of skilled nurses far more than a mere "convenience." Dr. Holloway's lack of objectivity, although entirely understandable, is obvious.

*Conclusions of Law*

This court agrees with the parties that the court has subject matter jurisdiction pursuant to ERISA, has jurisdiction over the parties and that the transfer from California to this court was appropriate.

Blue Cross begins its post-trial brief with this statement:

> It is difficult to imagine a more rational, reasonable and good faith administrative review that could have been provided for Plaintiff's claims, given the circumstances. Dr. Holloway gave impartial and

> thoughtful consideration to all of the arguments raised by Plaintiff, free from any demonstrable appearance of a conflict of interest. Every conclusion she reached makes sense.

This is an almost perfect example of proof by bold assertion. With this bold, uncritical assertion the court respectfully disagrees, and therein lies the tale.

The court may have been wrong to interrupt this proceeding to require Nightingale to exhaust review procedures required by the Plan. Perhaps this court should have realized from its intimate experience long ago as a lawyer in *Glover v. St. Louis-San Francisco Railway Co.*, 393 U.S. 324, 89 S.Ct. 548, 21 L.Ed.2d 519 (1969), that a party cannot be required to exhaust himself simply for the purpose of exhausting a totally futile administrative remedy. Such a "remedy" is not *real* but is merely a built-in obstacle standing in the way of access to a meaningful and fair-minded forum. However, the "exhaustion" process employed in this case did serve to reinforce this court's belief, formed from the other evidence, that Blue Cross was and is so biased in favor of Intergraph that it negates Blue Cross's contention that its denial of benefits must be reviewed under the "arbitrary and capricious" standard. Anyone who could find on this evidence that Blue Cross was a totally disinterested, impartial third-party evaluator of Nightingale's claims must be considered as naive. Blue Cross argues that because it was compensated only by a percentage of "claims paid," it *cannot* have a conflict-of-interest and *cannot* lack objectivity. Blue Cross claims that the method of payment constitutes *absolute* proof of no bias, unless it proves bias in favor of claimants.

In *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 109 S.Ct. 948, 103 L.Ed.2d 80 (1989), the Supreme Court recognized that a decision to deny ERISA benefits is subject to *de novo* judicial review unless the plan expressly gives the fiduciary discretionary authority in the matter of deciding claims. The Supreme Court went on to say:

> Because *we do not rest our decision on the concern for impartiality* that guided the Court of Appeals, see 828 F.2d, at 143-146, *we need not* distinguish between types of plans or *focus on the motivations of plan administrators and fiduciaries*. Thus, for purposes of actions under s 1132(a)(1)(B), the *de novo* standard of review applies regardless of whether the plan at issue is funded or unfunded and regardless of whether the administrator or fiduciary is operating under a possible or actual conflict-of-interest. Of course *if the benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict-of-interest that conflict must be weighed ...*

*Firestone*, 489 U.S. at 115, 109 S.Ct. at 957 (emphasis supplied). The Eleventh Circuit picked up this theme in *Brown v. Blue Cross & Blue Shield of Alabama*, 898 F.2d 1556 (11th Cir.1990). In *Brown*, the Eleventh Circuit held:

> The *disinterested, impartial decisionmaker deserves the greatest deference*. "Where ... the claimant does not argue or is unable to show that the trustees had a significant conflict-of-interest, we reverse the denial of benefits only if the denial is completely unreasonable." [citation omitted].

*Brown*, 898 F.2d at 1564 (emphasis supplied). The Eleventh Circuit then concluded with this highly relevant holding:

> We emphasize the central theme of our exposition: well-established common- law principles of trusts teach that a *fiduciary operating under a conflict-of- interest* may be entitled to review by the arbitrary and capricious standard for its discretionary decisions as provided in the ERISA plan documents, but *the degree of deference actually exercised in application of the standard will be significantly diminished*. A court should not exercise de novo review, but *the area of discretion to which*

> *deference is paid must be confined narrowly to decisions for which a conflicted fiduciary can demonstrate that it is operating exclusively in the interests of the plan participants and beneficiaries. Even a conflicted fiduciary should receive deference when it demonstrates that it is exercising discretion among choices which reasonably may be considered to be in the interests of the participants and beneficiaries. The fiduciary, however, should bear the burden of dispelling the notion that its conflict-of- interest has tainted its judgment. If the fiduciary carries this burden, the party challenging its action may still succeed if the action is arbitrary and capricious by other measures.*

*Id.*, at 1568 (emphasis supplied). Blue Cross here makes the same argument it made in *McDaniel v. Blue Cross & Blue Shield of Alabama*, 780 F.Supp. 1363 (S.D.Ala.1992), to which the district court wisely responded:

> Plaintiffs argue that the degree of deference should be diminished because Blue Cross' payment of claims directly affects its long term relationship with AAWA. *Blue Cross counters that it is reimbursed for all claims paid and that its fee is calculated based on the percentage of claims paid. Therefore, the argument goes, it is in the interests of Blue Cross to pay claims.*
>
> *The Court notes that it could not possibly be in the best interests of Blue Cross to pay every claim submitted.*

*McDaniel*, 780 F.Supp. at 1365 (emphasis supplied). This court necessarily agrees with the Eleventh Circuit in *Brown* and happens to agree with the court in *McDaniel*. In addition, this court finds that $93,000.00 of Intergraph's money in Blue Cross's bank account, bearing interest, and replenished weekly, provided ample self-interest and a substantial Blue Cross motive for not "exercising discretion among choices which reasonably may be considered to be in the interests of the participants and beneficiaries," to

borrow a crucial phrase from *Brown*. Any business would like to have a constant $93,000.00 to invest. Blue Cross has not borne "the burden of dispelling the notion that its conflict-of-interest tainted its judgment," to borrow another central phrase from *Brown*. This court concludes that the provision for compensating Blue Cross only on a percentage of "claims paid" does not constitute absolute proof of disinterest, but is more likely a disguise. The arrangement looks like a good lawyer's idea of a way to fend off the conflict-of-interest charge. Blue Cross's judgment was tainted. What was apparent to the district judge in *McDaniel* is apparent to this court. Blue Cross's attempt to hang its hat upon *Bruch* and to reinflate the rapidly evaporating deference due a biased decider is transparent. In the instant case, Intergraph was Blue Cross's customer. Intergraph would cancel this very lucrative contract in the blink of an eye if Blue Cross should ever let its obligation to the beneficiaries outweigh its "cost containment" obligation to Intergraph. Blue Cross is too sophisticated not to know how its bread is buttered.

Blue Cross's conflict-of-interest in this case would be obvious even if the court could overlook the impact and precedential effect of paying more than the *pre-determined* $19.00 per hour for skilled home nursing services would have had on Blue Cross's own insured plans. Nothing could impact Blue Cross more adversely than paying substantially more for treating AIDS patients under the Intergraph plan than it pays under its own medical benefit plans containing identical language. Could anyone doubt that if Blue Cross had paid Nightingale $47.50 with Intergraph's money it would shortly thereafter have had to pay a specialized AIDS nursing service $47.50 out of its own pocket? The overriding loyalty of all loyal Blue Cross employees was, not unexpectedly, to Blue Cross. This was no more than human nature. Employing common sense, then, this court knows that Blue Cross was operating under a not-too-subtle conflict-of-interest. It was as if Intergraph installed a fox to watch its employee's chickens. This finding is made easier by the fact that *Brown* firmly

places on Blue Cross the burden of proof on this issue. Blue Cross has not met that burden.

To recapitulate, Blue Cross is not an altruistic enterprise. The "discretion" ostentatiously given Blue Cross as Claims Administrator by Intergraph contained reins, as a practical matter, on Blue Cross as tight as if Intergraph had been handling its own claims. The court has reached this decision based on the evidence and has not depended upon the court's accidental reading of a relevant investigative report which serendipitously appeared in *The Birmingham News* on August 16, 1993.[1]

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[1] Blue Cross and Blue Shield is the largest and oldest health insurance organization in the United States, with more than 100 million subscribers.

* * *

Although the Blue Cross plans are supposed to be non-profit, [Senator] Nunn ['s] committee reports talk of a "corporate culture" in which executives operated their plans as if they were Fortune 500 companies.

* * *

Traditionally, Blue Cross plans collected premiums from policyholders and paid doctor and hospital bills. Their premium levels were expected to remain lower than for-profit companies, thanks primarily to tax exemptions bestowed on Blue Cross plans. But as medical costs began to increase nationwide, Blue Cross officials in some jurisdictions looked for new lines of business, apparently hoping to augment the income they received from policyholders.

* * *

But Princeton University professor of health policy Donald W. Light is blunt in his assessment.

"By their own choice, Blue Cross plans no longer serve any significant public function," he wrote, calling them "commercial companies in the guise of public interest, non-profit institutions....

Their self-perpetuating boards exhibit a striking lack of stewardship and public responsibility." Sheila Grissett, *Several Blue Cross Plans in Failing Health*, The Birmingham News, Aug. 16, 1993, at 1G.

An interesting question arises regarding whether Blue Cross or Intergraph is picking up the tab for defending this case. Because the contract between Blue Cross and Intergraph does not speak to the question, it will require a side understanding, either written or oral, between Intergraph and Blue Cross to decide who pays the lawyers. If Intergraph is responsible, that fact would constitute yet another piece of evidence to support the proposition that Blue Cross's interest and Intergraph's interest are identical, but it might also make Intergraph an indispensable party defendant under Rule 19, F.R.Civ.P.

In their post-trial briefs, the parties used many pages operating under Blue Cross's hopeful assumption, and under Nightingale's "fall-fact" assumption, that this court should give considerable deference to Blue Cross's and Dr. Holloway's decisions because the Plan grants decisional discretion to Blue Cross, as in *Bruch*. This court finds no purpose to be served in undertaking to decide whether Blue Cross's initial decision, as rubberstamped by Dr. Holloway, represents an abuse of discretion (i.e., was arbitrary and capricious), because to do so would be a redundancy. The court would, in effect, be responding to a hypothetical question. The facts here call for this court to nudge as close to a *de novo* review of the evidence as *Brown* permits, and here the gap is so narrow as to be almost imperceptible.[2]

The parties have also spent considerable time debating Nightingale's estoppel theory based on pre-certification telephone conversations and *Kane v. Aetna Life Ins.*, 893 F.2d 1283 (11th Cir.1990). *Kane* requires the court to find a plan document ambiguous before looking to promises outside the plan document for any clarification upon which a party can rely. This court respectfully declines to utter *dictum* on this subject any more than on the question of whether or not Blue Cross abused its discretion. Instead, this court has arrived at its ultimate

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[2] *See also Doe v. Group Hospitalization and Medical Services*, 3 F.3d 80 (4th Cir.1993).

conclusion of liability in favor of plaintiff and against defendant by giving very little deference to Blue Cross's decision in light of the conflict-of-interest with which it was afflicted and could not shed, and by a finding on the credible evidence that Blue Cross and Dr. Holloway were simply wrong on the facts and law to deny Nightingale's claim.

By paying $19.00 per hour while the intravenous tubes were sustaining Lungarella, Blue Cross conceded that skilled home nursing services were "medically necessary" before those tubes were removed. Therefore, the only factual dispute to be resolved during this abbreviated period is whether Nightingale's charges were "reasonable" for the services rendered during that period. The slippery word "reasonable," as used here to describe a bill or a charge, does not contemplate that there can be only one "reasonable" charge for the particular service or item furnished. "Reasonable" means "conformable to reason," or "rational," or "honest," or "not excessive," or "not arbitrary." More than one charge for the very same service could, in theory and in fact, be "reasonable." In this case, because of the considerable disparity between $19.00 and $47.50, and because each party seems to argue that only *its* hourly rate is "reasonable," the court is faced with a choice between $19.00 and $47.50. For the court simply to split the difference or to compromise somewhere between the two advocated figures might be arbitrary. Because All Care charged $50.00 per hour for similar specialized services in 1992, even though undoubtedly inflation had raised All Care's rates somewhat from those it charged in 1987, this court concludes that the $47.50 per hour charged by Nightingale while "IV's" were in place was not only Nightingale's "regular and customary" rate but was "reasonable" and, therefore, was due to be paid. Blue Cross's $19.00 pre-determined rate contained no recognition of the highly specialized and risky nature of home service to AIDS patients; however, it is *reasonable* to assume that there is a *reason* for a considerable differential between the cost of routine skilled home nursing service and the cost for nursing AIDS patients. To

recruit nurses for treating AIDS victims must be like recruiting kamikaze pilots. It takes a special breed.

There is another method of analysis for determining the "reasonableness" issue. However, the court is lead to the same conclusion. Starting with the dubious premise that some deference is due Blue Cross in determining whether Nightingale's charge was reasonable, that deference is offset, and perhaps more than offset, by the Alabama rule of contract construction which construes imprecise language in an insurance contract against the insurer-draftsman and in favor of the insured. The Eleventh Circuit in *Jordan v. National Accident Ins. Underwriters, Inc.*, 922 F.2d 732 (11th Cir.1991), recognized this Alabama doctrine with the following language:

> Alabama courts construe ambiguous insurance policies "liberally in favor of the insured and strictly against the insurance company." *Champion Ins. Co. v. Wilkins*, 544 So.2d 965, 967 (Ala.1989), citing *Ho Brothers Restaurant, Inc. v. Aetna Casualty and Surety Co.*, 492 So.2d 603, 605 (Ala.1986).
>
> This is an ambiguous policy because it does not define the terms that set out the limits of coverage. The cases cited by both parties ... illustrate the variety of interpretations that courts have given to "pilot," "passenger," "member of the crew" and other key terms in the policy. Some of these courts have adopted the moment of impact test in construing these terms, *see e.g. Vander Laan [v. Educators Mutual Ins. Co.*, 356 Mich. 318, 97 N.W.2d 6 (1959) ], while others have rejected it, *see e.g. Beckwith [v. American Home Assurance Co.*, 565 F.Supp. 458 (1983) ]. As we said in another case in which we were called on to interpret an ambiguous policy provision in light of conflicting case law, "[u]nder Alabama law, if an insurance contract provision is subject to more than one interpretation, it should be construed in favor of coverage, and against the insurer." *Colbert County*

*Hospital Board v. Bellefonte Ins. Co.*, 725 F.2d 651, 654 (11th Cir.1984).

> Faced with the ambiguity created by the conflicting case law, Reliable could have limited coverage by defining the key terms in the policy so as to expressly rule out the moment of impact test. It could have defined "pilot" as "any person who operates any flight control at any time during the flight in question," but it did not. It now asks us to read this definition into the policy. This we cannot do in light of Alabama law's strong policy requiring that ambiguous insurance policies be construed against the insurer. *See Champion*, 544 So.2d at 967.

*Jordan*, 922 F.2d at 734-35 (footnotes omitted). Here Intergraph-Blue Cross could have defined "reasonable charge" as "the rate being paid regularly and customarily by Blue Cross for similar services in Alabama." Instead, the Plan does not define "reasonable charge" for nursing services but does enigmatically define "charge" as

> the *reasonable* charge by a provider of covered services or supplies not exceeding the provider's *actual charge regularly and customarily made for these services or supplies*.

(emphasis supplied). Construing this language in favor of Lungarella- Nightingale and against Intergraph-Blue Cross, this court finds that Nightingale's $47.50 charge was not only no greater than its actual, regular and customary charge but was reasonable.

As far as the choice of language is concerned, Blue Cross could have anticipated the adverse financial impact that a flood of high cost AIDS claims would have. Blue Cross could have done what the medical benefits insurer did in *McGann v. H & H Music Co.*, 946 F.2d 401 (5th Cir.1991), namely, amend the Plan to severely limit its exposure to AIDS claims. However, Intergraph-Blue Cross did not choose this course of action. If

Intergraph-Blue Cross should win this case, it could accomplish indirectly what the insurer accomplished directly in *McGann*.

On the other hand, if Intergraph-Blue Cross had written the Plan to say, "We'll pay only what *we* deem reasonable," the Plan would undoubtedly not have been well received by Intergraph's employees. The agreement might not even have qualified as an ERISA plan. Yet, this is the interpretation Blue Cross seems to want to give the language.

The second ultimate mixed question of fact and law is whether skilled nursing was "medically necessary" after the removal of the "IV's." Although a court cannot allow itself to be swayed by sympathy, it can be influenced by practicality and by how the real world works. A caring family can and should provide loving care for a dying family member like Lungarella, even when that dying member has a dread disease which is highly contagious and very messy. Strangely, eventually, even Dr. Holloway conceded that some skilled nursing was "medically necessary" after the "IV's" were removed. As previously stated, this court finds it hard to understand exactly how Dr. Holloway arrived at the amount of additional reimbursement. Perhaps Blue Cross sought to appear to be fair. As a practical matter, however, when was the Lungarella family supposed to call for nurses? Dr. Holloway did not say. Not only Lungarella, as the dying patient, but his family, needed the comfort and sense of support which comes automatically with the physical presence of trained nurses. The joint decision of Lungarella and his family to remove the "IV's" was a rational decision; however, the family's decision would appear irrational had they, at that time, understood that the change would automatically cut off reimbursement for skilled nursing.

If $47.50 per hour was "reasonable" compensation for AIDS nurses responsible for "IV" introduction and monitoring, as this court has found to be true, the $42.50

charged for 1,132 hours of service rendered after the "IV's" were removed was likewise "reasonable." The terms "reasonable" and "medically necessary" are just as capable of being understood and applied by a layman such as this court as by a supplier-provider, a medical doctor or a "cost container." They are words which must be understood and applied under particular and often varying circumstances. In 1987, the AIDS plague was not as widespread as it is today and was probably less understood. This court is not prepared to say, as Blue Cross seems to be saying, that Nightingale was a charlatan company, seeking to exploit the AIDS plague for its financial aggrandizement. This court is not being asked to judge the relative rectitude of Nightingale and Blue Cross and does not mean to do so. Both plaintiff and defendant are in business to make money. Strictly on the evidence before the court, the court has concluded that Nightingale's charges were "reasonable" and were "medically necessary." Therefore, Blue Cross's sharply reduced reimbursement and its contention that most of Nightingale's services were not "medically necessary" constituted breaches of the Plan contract.

Perhaps the court has inadvertently done Blue Cross a favor. By the terms of Blue Cross's written agreement with Intergraph, Intergraph will refund Blue Cross all of the judgment which will be entered contemporaneously with this opinion, plus 5.2% for a "claim paid." Perhaps, also, the court was premature in starting this opinion with the comment that this case will provide no grist for the ERISA windmill, which grinds on.

An appropriate, separate judgment will be entered.

Dated: August 26, 1993.